

***United States Court of Appeals
for the Second Circuit***



**APPELLEE'S
APPENDIX**

77-1110

United States Court of Appeals

FOR THE SECOND CIRCUIT

Docket No. 77-1110

UNITED STATES OF AMERICA,

Appellee,

—v.—

JOHN M. WEBB,

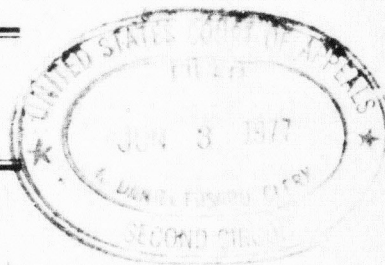
Appellant.

ON APPEAL FROM THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF CONNECTICUT

APPENDIX FOR THE APPELLEE

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INDEX TO APPENDIX

	<u>PAGE</u>
Report of Marc A. Rubenstein, M.D. Dated December 30, 1976	1
Direct and Cross Examination of Robert B. Miller, M.D..	4

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JAN 10 1977

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RECEIVED
JAN
OFFICE OF THE FEDERAL
PUBLIC DEFENDER, N.H.

December 30, 1976

Attorney Andrew Bowman
Federal Public Defender
U. S. Court
770 Chapel Street
New Haven, Connecticut

Re: John Webb

Dear Attorney Bowman:

As you know I have seen Mr. Webb at the Whalley Avenue Correctional Facility on three occasions (December 1, 8, and 11) with respect to your wish that he be examined in regard to his responsibility at the time of a Norwalk bank robbery in October, and also as to his present competency to stand trial.

With respect to the latter question, his mental status has given me some concern because at times he is actively psychotic. Probably the schizophrenic diagnosis he has been given during various psychiatric hospitalizations in recent years is quite just. My impression is that he is actively psychotic much of the time but varies significantly in his capacity to maintain as well an intact facade of adequate and conventional mental functioning. Thus, during the second of our three interviews he seemed to me so caught up in his disturbed mental processes as to raise serious question as to his competency. On that occasion (December 8) his thought processes so reflected the stigmata of a schizophrenic disturbance that he could not adequately deal with questions relating to the crime and to the impending legal procedures. At that moment his speech was interrupted by blocking, and was overly abstract, cryptic, and overburdened with ironic illusions that had no clear meaning. He seemed totally absorbed by a profound sense of depression or despair. However, by the subsequent meeting three days later he seemed much more intact and much more receptive to my insistence that he attend to matters at hand. I believe he has the potential for significant psychotic regression but I do not believe that this should interfere materially with your establishing a working relationship with him for the purposes of a trial.

The issue of criminal responsibility is obviously much more complex. As I have indicated, there seems to be little question that he has had a major mental illness for some time. His most recent psychiatric hospitalization, between March 4 and March 20 at Fairfield Hills

Hospital in Connecticut, seems to provide relatively convincing evidence that he was actively psychotic at that time. He had had previous psychiatric hospitalization at Stamford Hospital where he had been diagnosed as paranoid schizophrenic. Apparently his admission to Fairfield was brought about by the concern of an outpatient therapist as to his capacity to be managed outside the hospital. While at Fairfield he was noted to be "guarded and suspicious . . . having some ideas of reference with complaints of depression and preoccupation with sexual activity . . . seclusive and withdrawn for the most part of the day". Mr. Webb was discharged from Fairfield Hospital with a diagnosis of "schizophrenia, chronic undifferentiated type", and was referred back to his outpatient group therapy at Stamford Hospital where I believe he remained until some time in July.

In general my impression of Mr. Webb has been consistent with the observations recorded at Fairfield earlier this year. The blocking, tangential associations, cryptic significations which I noted are strongly indicative of the thought disorder characteristic of schizophrenia. Further, the preoccupation with sex which he describes and the quality of intense excitement which he exudes are also suggestive of the emptiness and disorganization of someone living perpetually on the brink of psychotic decompensation. Thus, in general, he appears to have a mental disturbance of significant proportion - one which potentially would be capable of impairing "substantially" his capacity to conform his behavior to the requirements of the law.

There are problems in attempting to relate this mental state to the alleged bank robbery of this last October. It is difficult to know with any reliability what his mental state at that particular moment was because the severity of his mental state seems to wax and wane regularly. Mr. Webb does not claim that at this time he feels to have been actively psychotic prior to the robbery. He mentioned "hearing voices" which told him to rob, but does not actively assert that that was a prime motivating factor.

The motivation for the robbery probably has to be looked at from several perspectives at once. On the surface it is obvious that there was a certain amount of planning and calculation. In one sense this is evidence of "effective" mental functioning, since it led to the "successful" robbery; in another sense it may not have been even superficially "effective" since, among other things, he "happened" to show the wig he intended to use as a disguise to a man whom he knew bore him a grudge (and who, predictably, seems to have been the one who later identified him for the police). At the level of superficially intact mental functioning his plan to rob the bank reflected his concern over rapidly diminishing resources. A business venture was about to flounder, and he felt unable to get support of any kind from his family. However, there

was also a very significant level of highly irrational thinking at that time as well. He justified to himself his plans to gain money illegally by likening his situation to that of the Viet Cong, who had to do what was necessary to "survive". The situation was one of rapidly deteriorating self-esteem; Mr. Webb has felt, since childhood, most strongly impelled toward anti-social behavior when he is feeling abandoned, depressed, and worthless. This has been true particularly since early adolescence when he recalls responding to a period of great emotional and financial difficulty in his father's life - which was undoubtedly quite troubling to him - by becoming mischievous and delinquent. It seems likely that Mr. Webb attempts to ward off, or compensate for, a devastating sense of emotional impoverishment by "filling up" with excitement - either anti-social, sexual, or both. It is obvious that his frequent allusions to his sense of sexual neediness refer not to genuine sexual longings but rather to his fear of becoming overwhelmingly depressed.

Mr. Webb's motivation for robbing the bank is undoubtedly connected to his psychotic disorder. In the sense that the underlying motives for seemingly "rational" or calculated behavior are often quite irrational (e.g., equating in fantasy his situation with the Viet Cong). This underlying psychotic process seems always to be there with relatively little remission in recent years. However, there seems to be considerable variability in his capacity to maintain a layer of intact mental functioning around this psychotic core. The rapid alternation in recent years of hospitalizations and briefly successful efforts at outside life, speak of this. It is probably important not to be overly impressed by the superficial rationality of his "plans" since they overlie a considerable amount of depression and psychotic irrationality. The situation is further complicated by Mr. Webb's tendency to "lean into" a psychotic-like state as he gets more discouraged or despairing. As with many psychotics, a certain amount of the psychosis is under some degree of voluntary control. The fact that he can pull himself together, when limits are placed upon him, does not mean, however, that he is not psychotic.

I find myself troubled by the specific question posed by an insanity defense: did he lack "substantial" capacity at the time of the crime? As I have indicated, there is no question that he has a very significant mental disturbance. Despite a certain level of seemingly rational calculation that went into the robbery it remains clear that to "some" extent his thinking was very much influenced by this disturbance. Whether that extent meets what the law requires by the word "substantial", is much more difficult to answer.

I hope these observations will be of help. Please feel free to discuss them further with me.

Sincerely,


Marc A. Rubenstein, M.D.

ROBERT B. MILLER, called as a witness by
the Government in rebuttal, having first been duly sworn,
was examined and testified as follows:

THE CLERK: Please state your name and address for
the record.

THE WITNESS: Robert B. Miller. Westport, Connecticut.

DIRECT EXAMINATION

BY MR. HARTMERE:

Q How are you employed, Doctor Miller?

A I'm employed by the State of Connecticut as
Superintendent of Fairfield Hills Hospital.

Q And how long have you been so employed?

A Between seven and eight years. Almost eight years.

Q Would you briefly describe your duties to the Court
and ladies and gentlemen of the jury?

A Well, by statute, I'm responsible for the day to day
running of Fairfield Hills Hospital, which is a state mental
hospital, with currently approximately 950 patients, and a care
giving staff of about 1200.

Q And do you have some background in the field of
psychiatry?

A Yes, I do.

Q Would you state that background, please?

A Yes. Originally, I was graduated from Princeton
University and from Loyola University College of Medicine.

Miller - direct

Subsequent to that, I interned in the Navy, and while in the Navy, in addition to other duties, was given postgraduate education in psychiatry, both at Bethesda Naval Hospital and at St. Elizabeth's Hospital in Washington, D.C., which is a government mental hospital, as you know.

Subsequent to that, I had various assignments in service, such as post psychiatrist at Paris Island, as division psychiatrist for the 2nd Marine Division in the field, and a number of other such responsibilities while I was in the Navy.

Subsequent to leaving the Navy in 1947, I then had various additional training at Kings Park State Hospital in New York State, at New York State Psychiatric Institute, at Montefiore Hospital in New York.

In -- and I can't remember exactly when -- 1948 or 1944, I took my examinations and was made a diplomate in the American Board of Psychiatry and Neurology.

In part-time private practice in New York, I was also variously consulting neurologist to Kings Park State Hospital, associate attending psychiatrist at Montefiore Hospital, director of psychiatry at the Hospital for Joint Diseases in New York, consultant in psychiatry to Memorial Hospital in Middletown, New York, consultant in psychiatry to the New York Guide for the Jewish Blind, consultant in psychiatry to the House of the Holy Comforter in New York, and also taught both

Miller - direct

undergraduate and postgraduate psychiatry at the College of Physicians and Surgeons of Columbia University.

In 1964, I came to Connecticut and became licensed in Connecticut. I should state parenthetically that I was licensed in the State of New Jersey in 1943, and in the State of New York in 1948.

I then came to Connecticut as chief of professional services responsible for all clinical procedures at Connecticut Valley Hospital in Middletown, New York -- Middletown, Connecticut -- briefly had additional duties in putting together what is now the Whiting Forensic Institute, though at no time was it open during my duties there; and then approximately seven and a half, eight years ago, was made Superintendent of Fairfield Hills Hospital, a position which I still hold.

In addition to that, I hold membership in a number of organizations, such as being a fellow of the American Psychiatric Association, a fellow of the New York Academy of Medicine, a member of the County and State Psychiatric and Medical societies. As a member of the State Medical Society I was on, while it existed -- the liaison counsel between the bar and the medical society, and for the med' -- for the psychiatric society, currently am a member of their society on legal problems. Or their committee on legal problems, I should say.

In addition to that, as you know, I have done a good

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Miller - direct

deal of forensic psychiatry, and have examined, and/or testified on -- in excess of a thousand cases related either to the question of fitness to stand trial or to the question of sanity at the time of an offense.

Q Now, as to the times you have testified and conducted examinations, were they all on behalf of the government or the state?

A I would say about two-thirds are on behalf -- on the side of prosecution -- I won't say the side of -- but employed by prosecution, and about one-third by either private counsel or public defenders.

Q Now, Doctor, do you know the defendant, John Webb?

A I have examined him, yes.

Q And was that on December 29 --

A Yes, it was.

Q -- 1976?

And what was the length of your examination?

A Somewhere between an hour and an hour and a half. I think closer to the latter.

Q And did you, as a result of your examination on December 29, arrive at a diagnosis -- the defendant?

A Yes, I did -- arrived at several diagnoses, as a matter of fact, one of which was immediately germane to the report.

Q Did you base those diagnoses solely on what the

Miller - direct

defendant told you?

A. No.

Q. What else did you base your diagnoses upon?

A. In addition to my examination, with the patient's consent, I also resorted to the records of a previous hospitalization which he had had at Fairfield Hills Hospital, which, in turn, had incorporated various documents and summaries, not only from the physician who had originally sent him to Fairfield Hills Hospital, but also from Stamford Hospital.

In addition to this, after I had examined him, but subsequent to writing my report, I had been provided with a copy of the report submitted by Doctor Rubenstein.

Q. Doctor, would you summarize what the defendant told you which you used as a basis for your diagnosis?

A. I don't know if I can do it as a summary, but if this will serve as a summary, it became obvious to me that the defendant, Mr. Webb, was aware of what he had done at the time he had done it.

That -- as a result of my examination and my evaluation, not only of his response to me, but also of the manner in which he made these responses -- that he was also capable of having conformed his behavior at the time of the acts in question; that there was an underlay of mental disorder which he suffers from. In fact, not only a mental disorder, but a moderate

Miller - direct

personality disorder, as well. But that -- well, I don't know whether this is part of the summary -- I came to a conclusion as a result of my examination, and as a result of the review of the records.

Is that an answer to your question which is adequate? I'm not sure exactly how to do it.

Q That's fine. What was your conclusion?

A. My conclusion was that he did not lack substantial capacity by reason of mental disorder, though he does suffer from a mild and intermittent form of schizophrenia. To know the wrongfulness -- or did not suffer to know the wrongfulness of his acts at the time he committed them, or to have conformed his behavior to the requirements of the law at the time he committed them.

Q And what was your diagnosis of the defendant?

A. My major diagnosis was that he was suffering from a minimal degree of a mixed type of schizophrenia and that, by and large, and for a long period of time, he has had a personality disorder of an antisocial type which I think could better be described as a psychopathic personality.

Q And would you explain what schizophrenia is?

A. This is a very difficult thing. I'll try.

Schizophrenia is a combination of signs and symptoms produced, insofar as we now know, by no specific physical

Miller - direct

condition, but what we call functional, manifested by some varying degree of thought disorder, the principal aspect of which would be an inability to evaluate reality satisfactorily; and at least as important, and even perhaps more diagnostic, a disproportion between the expression or evidence of whatever mood or emotion goes on in the patient, and the mood or emotion itself.

In addition to this, there are a number of subtypes. Actually, there are four principal subtypes, which are quite different from each other, though there may be a combination of symptoms, the most simple type of which is called simple schizophrenia, and is characterized not only by this disproportion between the mood and what comes from it, which we call effect, and, therefore, is called having a flattened and inappropriate effect, but also by a withdrawal from competitive contact with the world around to a degree which makes an individual virtually a hermit, and, in fact, a great many hermits could be diagnosed as simple schizophrenics.

Most usually, as an example is given, the individual who has a college degree and who for a while is able to compete satisfactorily in the world around him, but who then withdraws and is content to simply act as a crossing guard at some crossing where there's only one train a day or something of that nature.

Now, that is only one type. That's simple schizophrenia.

Miller - direct

Then, there is another and very different type called catatonic schizophrenia, which is a variant and which can be characterized either by extreme assaultive excited states, or, on other other hand, by withdrawal, negativism, and sometimes a bizarre symptom called waxy flexible, in which an individual can stand in one posture, arm raised, for instance, for a 24-hour period without moving, remains mute, and very frequently is characterized, when one can receive communications from such patient, by indications of delusions or hallucinations, usually of a religious nature.

Then, the next most important type which one would have is the paranoid type of schizophrenia in which there are delusions of persecution.

Perhaps I should stop a moment and define delusions as false, fixed beliefs, and hallucinations as falsely perceived input of one type or another.

But, in any event, delusions of persecution, ideas of reference which really mean the belief that the world centers around that individual, and that any two people talking or any minimal occurrence anywhere really has to do with the individual no matter how remote from reality that may be, suspiciousness and usually the suspicion and delusions of persecution can be quite circumscribed, but not always so. The individual who believes that he has been accused of starting the third world

Miller - direct

war, the individual who believes that television is conveying bad messages to the world around him, and so forth.

Now, these are the main types of schizophrenia, and then there is still one additional type, which is not unreasonable to find, I suppose, what we call a mixed type. Simply that an individual who has the basic disorder of, let's say, a flattened and inappropriate effect, may also show one or two of the signs or symptoms which would be diagnostic of one of the groups previously described, but not enough of these signs or symptoms to the exclusion of others to warrant the subgroup diagnosis which would be more specific.

Q Now, in your opinion, did the defendant, John Webb, fall into one of those categories?

A Yes. I would say to a minimal degree, but to a diagnosable degree, he did, in fact, fall into the category of mixed type of schizophrenia. He had no one sharp group of symptoms in sufficient quantity or to a sufficient degree to warrant making a more specific diagnosis. While, at the same time, there was a sufficient amount of schizophrenia to warrant arriving at a diagnosis.

Now, perhaps in mitigation of what I said, there are other ways, also, of classifying schizophrenia, and, obviously, whereas it is a serious disease, serious mental disease, it nevertheless, in some instances, can remit and the patient can

1 Miller - direct

2 improve substantially in a very brief time, and then, I suppose,
3 in the interests of proper diagnosis, one would diagnose such a
4 patient who had been clearly schizophrenic, and diagnosably so,
5 but who was now improved very perceptibly, one could make the
6 additional diagnosis of schizophrenia in remission.

7 Now, at the time that I examined Mr. Webb, I saw
8 evidence of schizophrenia, but no evidence of schizophrenia to
9 the degree which, for instance, were recorded in his hospitaliza-
10 tion stay at Fairfield Hills Hospital, which is not to say that
11 the hospital was incorrect, but that he had improved to such a
12 point and that it would be apparent that rather than having the
13 type of schizophrenia which would be long-term chronic and
14 continuously deteriorating, that apparently his responses to
15 stress were such that extreme stress could push him beyond the
16 edge briefly, but that his defenses were still sufficiently elas-
17 tic to enable him to reintegrate his defenses and once again
18 show evidence of no more than minimal schizophrenia and his
19 underlying and all pervasive character disorder.

20 Q Now, Doctor --

21 A Personality disorder.

22 Q Excuse me -- did you discuss the facts of the
23 robbery with the defendant?

24 A I asked him what he could recall of the robbery, yes.

25 Q Now, Doctor, assuming a well-planned robbery, or

Miller - direct

reasonably well-planned robbery, would this be consistent with your finding?

A. It is my belief that a paranoid schizophrenic, one who is merely paranoid, would be capable of such a robbery were he, in fact, a paranoid schizophrenic, but that the average schizophrenic would be incapable of the organized or systematized planning or the sustaining of the intent for the -- the actual act or for having planned it and then executing it.

Q. Doctor, do you have an opinion as to the defendant's substantial capacity to appreciate the wrongfulness of his conduct?

A. Yes, I do.

Q. And what is that?

A. That he does not lack substantial capacity to appreciate the wrongfulness of his conduct.

Q. And do you also have an opinion as to the defendant's substantial capacity to conform his conduct to the requirements of law?

A. Yes, I do.

Q. And what is that opinion?

A. That he does not lack substantial capacity to conform his behavior.

Q. Does your opinion also relate to the date of the robbery, October 13?

1 Miller - direct/cross

2 A Yes.

3 MR. HARTMERE: Nothing further.

4 THE COURT: Cross-examination.

5 CROSS-EXAMINATION

6 BY MR. BOWMAN:

7 Q Good morning, Doctor Miller.

8 A Good morning, Mr. Bowman.

9 Q Doctor Miller, you are Superintendent of Fairfield
10 Hills Hospital?

11 A Yes, I am.

12 Q And that's a state run mental hospital --

13 A Yes.

14 Q -- is that true?

15 And I think your testimony was that you have testified
16 in over a thousand cases?

17 A Approximately.

18 Q So that testifying in front of a jury is nothing new
19 to you, is it?

20 A No, it is not.

21 Q As a matter of fact, over the years, you have been
22 able to polish your skills as a witness, have you not?

23 A I wouldn't call it polishing my skills. I polish
24 my skills as a psychiatrist.

25 Q But with every experience you have had, you've sought

Miller - cross

to improve your performance as a witness --

A I'm not an actor, Mr. Bowman, I'm a psychiatrist.

Q Let me finish the question.

A Please, I'm not interested in performance.

Q No, I didn't -- I didn't mean to imply that you are an actor, but I'm saying that you are extremely skillful in taking the witness stand, having done it in the past in a thousand cases, is that true?

A I really don't know how to answer that, Mr. Bowman. It may be that I am less struck with stage fright, and I am capable of expressing what I believe, not necessarily more lucidly, but at least more consecutively, but, on the other hand, this is not polishing skills, this is simply that I believe that after some 35 years of doing psychiatry that I know what I'm doing and that my peers accept the fact that I know what I'm doing.

Q And how many years have you been testifying in courts?

A I've been testifying in courts even back in my days in the Navy when I used to testify at General Courts on occasion.

Q So for how many years is that?

A Thirty to thirty-five years.

On the other hand, my testimony, when I was not employed by the state, and having as a duty making these examinations, frequently was pretty limited until I became

1 Miller - cross
2 employed by the State of Connecticut.

3 Q Doctor, you testified on direct examination that
4 there were about 950 patients at Fairfield Hills Hospital?

5 A Yes.

6 Q And there's been a time in the very immediate past
7 when there were a far greater number, isn't that true?

8 A When I first became superintendent there, there were
9 some 2600 patients.

10 Q And over the past year, how many patients?

11 A Well, I think that the patient population averaged
12 somewhere between 950 and a thousand patients for some time now.
13 Although the admission and readmission rate at the hospital has
14 been running approximately 4500 patients a year seen by hospital
15 staff.

16 Q Have you been cutting, purposely cutting down your
17 patient load over the past year?

18 A Oh, unquestionably we've been cutting down patient
19 load deliberately in point of treating patients sufficiently
20 well to insure the fact that their ability to be restored to
21 their home and their activities as quickly as possible.

22 Q In the beginning of last year, let's say, how many
23 patients were there at Fairfield Hills, do you recall?

24 A No more than 1200. Again, it's a fluctuating number.
25 But, again, the deliberate cutting down of the number of patients

1 Miller - cross

2 is not an extrusion of patients, but rather the increased degree
3 of care given these patients and the increased number of programs
4 instituted to attempt, as I said, to restore as many people to
5 sufficient health to be in their homes and communities as
6 possible.

7 Q Did you take any notes of your interview with John
8 Webb?

9 A I took a few notes, enough to refresh me until I was
10 able to remember them better.

11 Q You examined him on December 23th, for the most, an
12 hour and a half, is that true?

13 A Yes.

14 Q And you didn't write your report until January 20th,
15 is that true?

16 A That's correct.

17 Q And you relied on your notes to write that report?

18 A Only minimally.

19 Q Do you have those notes with you?

20 A Mr. Bowman, when I write a report -- and this is one
21 of the first things I learned some 35 years ago -- I no longer
22 retain any documentation which is not officially necessary.

23 Q Okay. What did you learn 35 years ago that made you
24 feel that you had to destroy your notes?

25 A That there were times that perhaps notations of a

Miller - cross

confidential nature in terms of confidential disclosure by a patient might be invaded were the notes to be subpoenaed and brought to court.

Q But, Doctor, you know very well that the purpose of your examination was at the behest of the government, and there was a pending criminal case, you knew that, didn't you?

A Of course.

Q And you knew that you'd be called upon to testify in this case, did you not?

A The purpose of my examination was for the purpose of coming to court and indicating what I had found. And my conclusions.

Q So that if you knew you were going to testify in court at a later time, were you so confident that you could rely upon your memory at the time you testified in court, and that's why you destroyed your notes, or was it out of some interest in keeping confidential what John Webb had told you?

A Would you repeat that, because I'm not too sure I understood fully what you were saying?

Q Certainly. You knew that you were going to come to court sometime in the future to testify in this case, did you not?

A Yes.

Q And knowing that, you only took minimal notes?

Miller - cross

A I in many, many years -- both in private practice for forensic purposes, or even as I'm doing now, because a number of my doctors are really actually reviewing patients at the hospital -- I take no more notes than are necessary to actually guide me, and these are generally in relation to dates or specific times, rather than events or my own impressions.

Q Did you take notes on your review of the Fairfield Hills Hospital report?

A No, certainly not. I had the review -- I had the hospital report before me at all times, since you subpoenaed it, I have it here at this moment.

Q Certainly, and I also subpoenaed any memoranda that you made, isn't that true?

A You have to go to the garbage dump for that, Mr. Bowman.

Q So that we'll never know what was on that memoranda, what was on those notes?

A Well, that's an accurate statement, and by the same token, there's no point in your going, since what was on those notes is inked in my report.

Q Your report is a page and a half?

A I would have to -- yes. A page and a half is fair to state.

Q Page and a half, part of which is devoted to the

Miller - cross

question of competency to stand trial?

A That's correct.

Q Substantial portion of it?

A Again, I would have to review it to see what portion, Mr. Bowman.

Q Go ahead, Doctor, take your time.

A Well, I see two paragraphs which have to do with that. I don't know what else would have to do with that, except --

Q There are only seven paragraphs in your whole report, aren't there?

A Mr. Bowman, we're quibbling, but if there were two paragraphs related to that, and there -- as you appear to have counted, seven paragraphs, then it is not a substantial portion, if you do simple arithmetic.

Q Doctor, what I am trying to understand is the basis upon which you arrive at a medical opinion, and part of that basis, I assume, is contained in your report, part of which was contained in your notes, is that true?

A No, not at all. And I don't know how you arrived at that conclusion. The notes which I made were part of what guided my ultimately preparing my report. Once the report was prepared, the notes became worthless, since obviously the report is not only a record of what I had in the notes, but of what other conclusions I was able to draw as a result of not only Doctor

Miller - cross

Rubenstein's report to me, but the hospital record which I had before me at all times.

Q Wait a minute. Doctor Rubenstein's report wasn't to you, was it? It was to me, was it not?

A Did I say it was -- if I said it was to me, then I'm certainly in error. But it was supplied to me, to whomever it was addressed.

Q When John Webb was at Fairfield Hills, did you ever see him?

A No.

Q And that was back in March of '76?

A Yes.

Q Is it true, Doctor, that your staff, the staff psychiatrist who examined him at that time, had an opinion that his illness was much more florid than your opinion?

A Well, now, again, in fairness to you, Mr. Bowman, I must define -- staff psychiatrist means someone who is on the staff as opposed to someone who is there for training. Some of the younger doctors in training had such an opinion. On the other hand, the staff psychiatrist clearly did not have such an opinion in that this young man was originally sent to the hospital on a physician's emergency certification, not a commitment. That after 15 days, which was the expiration of such a physician's emergency certification, the patient was then

1 Miller - cross

2 considered as sufficiently competent and sufficiently able to
3 remain at the hospital as a voluntary patient, rather than send-
4 ing him to be certified -- or committed by the probate court,
5 which is the procedure required when an individual is incapable
6 of arriving at such determinations himself, and is considered
7 in need of retention.

8 Q My question, Doctor, is: did members of your staff
9 consider that John Webb's disease was much more florid in
10 nature than your opinion?

11 A They could not have, otherwise, he would not have been
12 discharged after such a brief hospital stay.

13 Q At the time of his admission?

14 A At the time of his admission, they went on the basis
15 of their examination without an adequate observation, yes.

16 Q And they medicated him when he was at Fairfield Hills?

17 A I do not recall that.

18 Q Would you like to review the report?

19 A Yes.

20 Q Take your time.

21 A No, there's no need, I can find this fairly quickly.

22 Yes. He was started on medication of a very minimal
23 quantity. He was given a particular medication at the level of
24 50 milligrams three times a day.

25 Q What was the medication?

1 Miller - cross

2 A The name of that medication was Thorazine.

3 Q What's Thorazine --

4 A And the average severely ill patient would be started
5 on something much closer to -- somewhere between two and four
6 hundred milligrams of Thorazine four times a day.

7 Q What's Thorazine, Doctor?

8 A Thorazine is a psychotropic medication, chlorpromazine.

9 Q What does that mean, Doctor?

10 A It means it is a medication used to hopefully -- and
11 in ways as yet unknown, since it is used empirically -- diminish
12 anxiety and enable an individual who has any severe anxiety to
13 stabilize his thinking more satisfactorily.

14 However, again, it is a medication which first was
15 developed in 1955 in this country, but had been in use in other
16 countries, particularly France, for a number of years prior to
17 that, and I might tell you, although clearly it does not apply
18 to your client, that its original use and its still occasional
19 use is for pernicious vomiting of pregnancy.

20 Q Doctor, at the time you wrote your report seven days
21 ago, had you examined Stamford Hospital records relating to a
22 January, 1973 admission to the psychiatric ward of John Webb?

23 A I examined no direct report from Stamford Hospital,
24 but only whatever was summarized of it in the Fairfield Hills
25 Hospital record, plus the physician's emergency certificate.

Miller - cross

Q Are you able to find that summary, which you relied on in coming to your conclusion, of his prior hospitalization at Stamford Hospital?

A Well, I have indications of it here, yes.

Q Read it, please?

A Well, first of all, a physician's certificate signed by Doctor Schneider -- Doctor Schneider being a staff psychiatrist -- stated --

Q That's Stamford? At Stamford Hospital?

A At Stamford Hospital -- stated that: "24 year old, white single male was admitted through the emergency last night because of regressive withdrawal culminating in a recurrence of feelings that, 'I am crazy,' and suicidal ideations. John has had two prior admissions, the latest last summer, diagnosed as paranoid schizophrenia."

Then there is some irrelevant material, and then: "The patient has really no treatment" -- I believe since this was one with a language difficulty, it should have been has had -- "really no treatment, and tends not to follow up in out-patient therapy."

There is also the note in the physician's certificate stating that the staff at Stamford Hospital feels that the Fairfield Hills Hospital would be more therapeutic than another repetition of symptoms.

1 Miller - cross

2 Q Did you know, Doctor, when you came to your opinion
3 before testifying here in court that in January, 1973, John Webb
4 had been admitted to Stanford Hospital for progressive feelings
5 of emptiness and apathy, inability to function, contemplated
6 suicide, loosening of association, and the prognosis was guarded
7 over the long term? Did you know that before you came to court
8 today?

9 A I knew some of that. I did not know that they had
10 said that the prognosis was guarded.

11 Q Well, you knew what you had read in that report,
12 isn't that true?

13 A No, I did not read that. This, I was told, as a
14 matter of fact, by your client, Mr. Webb.

15 Q Mr. Webb?

16 A And I had no reason to disbelieve this is so.

17 Q And at that time he was diagnosed as having a
18 schizophrenic reaction?

19 A Yes.

20 Q And when you came to your conclusion, had you examined
21 the medical records of Stamford Hospital relating to an August
22 9, 1975 through September 19, 1975 admission at the psychiatric
23 ward there of Mr. Webb?

24 A Is this the one which related to an overdose which
25 Mr. Webb had taken?

1 Miller - cross

2 Q That's right.

3 A No, I did not examine it, but I was aware of the
4 incident and the fact that he had had, in fact, prior admissions
5 at Stamford Hospital, and the fact that he had had such a
6 diagnosis appended to him at Stamford Hospital was, in fact,
7 taken into consideration by me.

8 Q Doctor, what's Mellaril?

9 A Mellaril, again, is a psychotropic medication, which
10 has an effect not at all unlike Thorazine.

11 Q Congentin?

12 A Congentin is a drug which acts on the extraparamatel
13 tracts of the central nervous system to counteract the possible
14 side effects, such as extramovements and rigidity which sometimes
15 are produced by drugs, such as either Thorazine or Mellaril,
16 and is not in and of itself used in the treatment of anything
17 except the side effects produced by the drug which is used for
18 treatment.

19 Q All right. So that given the side effects of Thorazine
20 or Mellaril, these are not medications which you prescribe as a
21 matter of factly -- let me say these are medications which you
22 prescribe for someone who is suffering from serious mental
23 disease, is that true?

24 A Well, again, there are -- I don't know how to answer
25 that question except, of course, these are used in the treatment

Miller - cross

of serious mental diseases, but the question of seriousness has nothing to do with the degree of distress that the symptoms cause. So that, for instance, these drugs may be produced for situation X. They may be prescribed, but if two people who have situation X have different degrees of symptomatology, they would be given different quantities of the medication.

Q Doctor, did you read Doctor Arthur Mode's report, who is the examining psychiatrist in the August, '75 admission of Mr. Webb to Stamford Hospital?

A No, I did not.

Q Then, you weren't aware that at the time Mr. Webb was admitted to that hospital, he was having both auditory and visual hallucinations? Were you aware of that or not?

A Well, there is no way one can be aware of it. Based on reading somebody's report, since both hallucinations and delusions are purely subjective phenomena, which are reported just as the question of headache would be reported.

Now, if a Doctor recorded them, I would be aware had I read his report that he believed that the patient was suffering from these conditions, and then I would have respected his judgment. But this would have made me aware that the patient had had them.

Q But you didn't know that, you didn't know what Doctor Mode had written in his report?

1
2 Miller - cross

3 A It was of no moment. No, I didn't know it.

4 Q Whether a person is having auditory or visual hallucina-
5 tions is of no moment?

6 A If you have a rash with measles six months ago, it is
7 of no moment in terms of making a diagnosis at this particular
8 time, except on an exclusory basis. The hallucinations and
9 delusions are symptoms, at any time, or symptoms of a disorder,
10 just as, let's say, cough and pain in the chest may be a symptom
11 of pneumonia. When the pneumonia is cleared up, at that
12 particular point, the fact that I might be aware that somebody
13 had had a cough and a pain in the chest a number of years ago,
14 would not have anything to do with the arrival of a diagnosis
15 by me of the examination -- related to an examination of a
16 patient at this time.

17 Q Would the fact that Doctor Mode noted that Mr. Webb
18 was picking up psychic mind waves and felt that the word "heresy"
19 was following him around, and that it was being spoken by what
20 sounded like a witch, would that change your opinion?

21 A It would change my opinion only insofar as agreeing
22 that at the time he was examined by Doctor Mode, or whoever --
23 I don't know the name -- that he may very well have been suffering
24 from a degree of illness which required some intercession then,
25 which has little or nothing to do with what he was suffering
from at the time of my examination.

1
2 Miller - cross

3 Q Doctor, when you came to your conclusion, had you
4 examined the Stamford records with respect to the March 3, 1976
5 admission?

6 A No. Only -- unless, without specific referral to
7 date, this was in any way incorporated in the Fairfield Hills
8 record.

9 Q So you didn't know that at the time he was admitted
10 to Stamford Hospital the day before he came to Fairfield Hills
11 he was admitted with suicidal ideation, depressed affect, and
12 that his thinking was constricted?

13 A I believe that is somehow or another recorded somewhere
14 in the Fairfield Hills chart. But, once again, that was
15 immediately prior to his hospitalization at Fairfield Hills in
16 March, and my examination was as to his condition not only at
17 the time I examined him, but what I could put together based on
18 this and past history, which included the purported schizophrenic
19 breaks for what might have occurred at the time of the offense.

20 Q Well, Doctor, doesn't the '73 admission, '75 admission,
21 '76 admission -- doesn't that suggest to you a chronic mental
22 disease?

23 A No.

24 Q No?

25 A It does not. In fact, if this will help -- and I
don't even know if it is relevant -- there are people with

Miller - cross

schizophrenia who are admitted to the hospital when they are young, and who, to all intents and purposes, never really get out of the hospital again. There are people with a clear-cut diagnosis of schizophrenia who leave the hospital in a relatively short time and are quite capable of functioning quite adequately in every respect, including socially, for varying periods of time, and who are not overtly schizophrenic until something comes along and produces another episode. But, on the other hand, they are not continuously schizophrenic because one appended a diagnosis to them at one time in the distant past.

Q Doctor, what symptoms would you have had to see to have changed your opinion that you did not see?

A To change my opinion as respect to what?

Q With respect to Mr. Webb's substantial capacity to conform his conduct to the requirements of the law, or appreciate the wrongfulness of his conduct?

A I would have had to have seen a considerably greater degree of thought disorder, some concrete evidence of what -- for want of a better word -- we call regression or dilapidation which would have indicated that the disorder itself had been ongoing and continuous, rather than intermittent, and I would have wanted to see a considerably lesser degree of brightness and alertness and keenly aware responsiveness to the course of the interview.

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Miller - cross

Q What is your opinion, Doctor, of Doctor Marc Rubenstein's diagnostic abilities?

A I think that Doctor Rubenstein is an excellent physician, to the extent of my knowledge.

Q He spent three sessions with Mr. Webb and reviewed four complete hospital reports, took extensive notes, and you spent one hour with him.

Was it prudent -- was it more prudent for Doctor Rubenstein to spend a more extended period of time with Mr. Webb than you did?

A It was neither more nor less prudent on either part. Apparently, at the time that Doctor Rubenstein examined him he may have found something which made him have a need to pursue the matter further, whereas, at the time of my examination, the situation seemed quite clear-cut to me based on my training and experience.

Q Did Doctor Rubenstein have a more substantial amount of data upon which to base his opinion than you do?

A I really don't think so.

Q In other words, the fact that he had seen him three times and you'd only seen him once didn't make any difference?

A May I answer you by analogy?

Q I'd like an answer from yes or no.

A Well, I can't answer that question without expanding

it in some sense.

Q Did you see any thought disturbances when you spoke with Mr. Webb on December 29?

A Yes, I did.

Q Did you see gaps between his thoughts?

A I don't even know what that means.

Q Did you see any unusually pervasive feelings of despair?

A No, I did not.

Q And did you see any fear of death?

A No. I did not.

Q Fear of falling apart?

A What I saw in relation to fear of falling apart could not be described in those words. I saw a considerable degree of anxiety on the part of Mr. Webb, which, again, based on my experience, is certainly not at all unreasonable in anyone awaiting disposition of a fairly serious case. In fact, were I not to see such response, I would consider that abnormal.

Q Did you see this chaotic and disorganized thinking at all?

A I saw some scatter of thinking. I would not have called it chaotic. There was some disorganization of thinking in that there was some skipping around, but, on the other hand, again, not to such an extent as to influence me toward believing

Miller - cross

that this would have produced some substantial lack of capacity for his ability as related to the stipulations of this defense.

Q Is thought disorder the hallmark of schizophrenia?

A I would say it is one of the important hallmarks, but is not in and of itself a specific thing which one would arrive at a diagnosis about only because of thought disorder.

Q I gather you do see patients up at Fairfield Hills. --

A Yes.

Q -- from time to time?

A Yes, yes, I do.

Q And, by the way, how many patients had you seen between the time you saw Mr. Webb on the 29th of December and the time you wrote your report on January 20th?

A I really can't say. One morning a week substituting for one of my sick doctors, I see those patients who are admitted the night before to the hospital from the entire western third of the State to determine whether or not their admission was suitable, which, by the way, I might add is frequently at some dissidence with more junior members of my staff. On the other hand, in relation to cases for forensic purposes, four, three, something like that. I can't say accurately.

Q How many would you say you saw? Between December 29 and January 20th?

A For forensic purposes, three or four at the outside.

Miller - cross

From the standpoint of the holding night admissions ward,
possibly a dozen.

Q So three weeks later when you wrote your report you
had a clear recollection of what you had seen on December 29th?

A Yes.

Q No question about that?

A None.

Q When you see patients up at Fairfield Hills, do some
of them exhibit more florid symptoms one day than they do the
next?

A There are inevitably fluctuations either related to
the diagnostic category or related to the degree of effective-
ness of whatever therapeutic regime has been instituted, or
related to stress, such as a disturbing visit.

Q And that's true of your long-term patients, also,
isn't it true?

A Yes. Except that the swings would be considerably
less remarkable, but there would be changes from time to time.

Q I gather that from time to time you speak with your
patients at Fairfield Hills? Ask them how they are? Carry on
casual conversation?

A Certainly not with every one, but, on the other hand,
yes, I'm available to patients and patients do talk with me. I
stop and talk with them on the grounds.

Miller - cross

Q And there are some who are extremely ill and can carry on a conversation with you, isn't that true?

A Well, here we come into semantics. When you say carry on a conversation, there's a considerable difference between carrying on a conversation, such as you would be able to do with me, were you to so choose, and someone who is disoriented and confused and disjointed or talking utter nonsense, as the case may be. They're carrying on a conversation, but it's not a reasonable one.

Q So that what you are saying is that someone might be able to say some responsive words to you, but not necessarily be able to appreciate what you are saying to them and what they're saying to you?

A More or less.

Q So there is a difference between knowing what somebody says and appreciating what somebody says?

A No, not really.

Q Comprehending?

A This is a semantic difference with such an overlap that whereas at either end of such a statement, like "knowing" on the one hand, or "appreciating" on the other, that it is conceivable that one could nit-pick enough to find differentiation.

I think in the looseness of usage of the English

1 Miller - cross

2 language, "knowing" and "appreciating" pretty much interchange,
3 mostly, but "appreciating" seems to be much more of a specialized
4 legalese.

5 Q And that's your opinion, is that right?

6 A That's my opinion.

7 Q And you know that the law used to be whether or not a
8 person knew the wrongfulness of his conduct, is n't that true?

9 A To the extent of my knowledge, since, obviously, I'm
10 not an attorney, this still obtains in Superior Court, in the
11 State Court, or at least I believe it does -- I can't say --
12 and I can only tell you that when I write reports for the
13 State Court, I use "know" or "knew" where I might very well have
14 used "appreciate", and this is simply my language, because I'm
15 not sufficiently learned in the mazes of the law to make such a
16 differentiation.

17 Q You know the old M'Naghten rule, don't you, Doctor?

18 A I more or less remember it, but --

19 Q A person knew right from wrong -- whather a person
20 knew right from wrong, that was the question --

21 A Yeah.

22 Q -- isn't that true?

23 And you are aware, are you not, that there's been a
24 tremendous amount of literature written in medical and legal
25 journals with respect to why the law was changed to include the

Miller - cross

word "appreciate the wrongfulness of one's conduct"?

A I am -- I can't speak as to the legal journals. I know that there is a good deal of verbiage expended in what, to me, at any rate, are philosophical dissertations, which, from the standpoint of a physician practicing psychiatry, seem to have, you know, little value in terms of, again, what I believe, and, again, very frequently I use the word "believe" as related to "know", and this clearly could be picked apart semantically.

Q Your opinion is that it is semantics?

A Yes.

Q Nothing more?

A Well, let' me put it this way: it is semantics insofar as the applications to which I might put it, whereas, perhaps some more scholarly person might be infinitely more precise in his selection of the exact word. Unfortunately, I'm not.

Q Do you know that the law requires the government to prove beyond a reasonable doubt that the defendant did not lack substantial capacity either to appreciate the wrongfulness of his conduct -- do you know that -- or to be able to conform his conduct?

A Well, if I didn't know it, I certainly know it now.

Q Did you know that when you wrote your report?

A Pardon?

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Miller - cross

Q You didn't know that when you wrote your report?

A I really can't honestly say whether I knew that there was a difference between "know" and "appreciate" in terms of specific words used, since, to me, regardless of what it might be for someone else, I use them interchangeably.

Q Would you agree, Doctor, that emotional processes as well as intellectual processes play a part in the concept of appreciation?

A Well, clearly, there has to be some taking into account input from the various senses, otherwise, we wouldn't have things such as in school music appreciation courses.

Q And, really, the concept of "know" only takes into account what we call the cognitive quality, isn't that true?

A It would be fair to state that.

Q And "appreciation" is much more than that, is it not?

Not -- it is more than that. I would certainly admit it. But not in the manner which would be significant to the determination which it was my duty to attempt to arrive at.

Q Let's take an example. We have a biblical commandment: "Love thy neighbor as thyself." How many people would you say know that?

A Oh, it would seem to me that very few people do not know it.

Q And how many people would you say appreciate it? The

Miller - cross

same number?

A Well, here, again, we start playing with words. I would think that anyone who knew that would appreciate it, whether or not they honored it.

Q Let's say you have a parent who knows, who is convinced in his own mind that it is wrong to beat his child, and, yet, the child does something and the parent is so overcome with anger that he beats the child. Would you say at that moment that he appreciates the wrongfulness of what he's doing? Even though he knows it is wrong to beat that child?

A I would not use either word, if you want to know the truth. I would say that he believed that what he was doing was against what he ordinarily went by, and may have had some remorse or guilt about it, but I don't know whether either "know" or "appreciate" would be as significant as, to me, the word "believe, since, clearly, this was a judgmental thing on his part.

Q Overwhelmed by the emotion of the rage over what the child had done? Would that affect his appreciative processes?

A Pardon?

Q Would that affect his appreciative process?

A I think that you had better get in a professor of English here. Again, I can't answer those questions with any degree of authority, since, clearly, my use of language is

Miller - cross

different than what you want me to use.

Q Well, it is not what I want you to use, Doctor, it is what the law requires you to use. Did you know that before you came to court to testify here as an expert?

A Only insofar as, to me, "know" and "appreciate" were the same, and if, in the course of dictation, I use the word "know" instead of using the word "appreciate" as far as I was concerned, it meant the same thing, and I can only apologize for offending your legal sense by using the wrong word.

Q Please don't apologize. Doctor, to you, it is nothing more than semantics, isn't that true?

A That's correct.

Q Doctor, do you agree with the report of the Royal Commission on Capital Punishment issued in 1953 that a criminal act may be coolly and carefully prepared, and yet be the result of a diseased mind?

A Yes, I do.

MR. BOWMAN: Nothing further, your Honor.

THE COURT: Redirect.

MR. HARTMERE: I have nothing further, your Honor.

THE COURT: You are excused, Doctor Miller.

THE WITNESS: Thank you, your Honor.

(Witness excused.)

THE COURT: May I see counsel --.

United States Court of Appeals
FOR THE SECOND CIRCUIT

No. 77-1110

U S A,
Appellee

vs.

JOHN M. WEBB,
Appellant

AFFIDAVIT OF SERVICE BY MAIL

Patricia D. O'Hara, being duly sworn, deposes and says, that deponent is not a party to the action, is over 18 years of age and resides at 51 West 70th Street, New York, New York 10023

That on the 3rd day of June, 1977, deponent served the within Brief and Appendix upon Andrew B. Bowman, Esq., Chief Federal Public Defender, 770 Chapel Street New Haven, Connecticut 06510

Attorney(s) for the Appellant in the action, the address designated by said attorney(s) for the purpose by depositing a true copy of same enclosed in a postpaid properly addressed wrapper, in a post office official depository under the exclusive care and custody of the United States Post Office department within the State of New York.

sworn to before me,

This 3rd day of June, 1977

Edward A. Quimby

EDWARD A. QUIMBY
Notary Public, State of New York
No. 24-3183500
Qualified in Kings County
Commission Expires March 30, 1979